

Schedule of Benefits

Employer: Howard County, Maryland

ASA: 622786

Issue Date: August 4, 2008

Effective Date: January 1, 2008

Schedule: 2A

Booklet Base: 2

For: Open Access Select Medical Plan

Select Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Lifetime Maximum Benefit per person</i>	Unlimited	Not applicable

Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the amount Aetna pays. You are responsible to pay any deductibles, co payments, and the remaining payment percentage. You are responsible for full payment of any non-covered expenses you incur.

PLAN FEATURES	NETWORK	OUT OF NETWORK
Routine Physical Exams Adults only. Includes coverage for immunizations	\$10 exam copay then the plan pays 100% No deductible applies.	Not Covered
Maximum exams per 12 consecutive month period		
Adult age 18 to 65	1 exam	Not Covered
Maximum exams per 12 consecutive month period		
Adult age 65 and over	1 exam	Not Covered
Well Child Exams Includes coverage for immunizations	\$10 exam copay then the plan pays 100% No deductible applies.	Not Covered

Maximum exams per 24 consecutive month period		
Under age 2		
first 12 months of life	7 exams	Not Covered
13th-24th months of life	2 exams	Not Covered
Maximum exams per 12 consecutive month period		
For age 2 to 18	1 exam	Not Covered
<i>Routine Gynecological Exam</i>		
	\$10 exam copay then the plan pays 100%	Not Covered
	No deductible applies.	
Maximum exams per Calendar Year	1 exam	Not Covered
<i>Routine Hearing Exam</i>		
	\$20 exam copay then the plan pays 100%	Not Covered
	No deductible applies.	
Maximum exams per 24 month period	1 exam	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Routine Cancer Screening</i>		
<i>Routine Mammography</i> For covered females age 35 and over	100% No deductible applies.	Not Covered
For covered females, age 35 but less than 40	1 baseline mammogram	Not Covered
For covered females age 40 and over Maximum tests per 12 consecutive month period	1 test	Not Covered
<i>Prostate Specific Antigen Test</i> For covered males age 40 and over	\$10 exam copay then the plan pays 100% No deductible applies	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered
<i>Routine Digital Rectal Exam</i> For covered males age 40 and over	\$10 exam copay then the plan pays 100% No deductible applies	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered
<i>Routine Pap Smears</i>	100% per test No deductible applies.	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered
<i>Fecal Occult Blood Test</i> Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered

Sigmoidoscopy Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum tests per 5 consecutive year period	1 test	Not Covered
Double Contrast Barium Enema (DCBE) Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum tests per 5 consecutive year period	1 test	Not Covered
Colonoscopy age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum tests per 10 consecutive year period	1 test	Not Covered
PLAN FEATURES NETWORK OUT-OF-NETWORK		
Physician Services		
Office Visits to Primary Care Physician Office visits (non-surgical) to non-specialist	\$10 visit copay then the plan pays 100% No deductible applies.	Not Covered
Walk-In Clinic Non-Emergency Visit	\$10 visit copay then the plan pays 100% No deductible applies.	Not Covered
Specialist Office Visits <i>All specialists except those specifically listed in this schedule.</i>	\$20 visit copay then the plan pays 100% No deductible applies.	Not Covered
Physician Office Visits-Surgery	Payable in accordance with the type of expense incurred and the place where service is provided .	Not Covered

<i>Physician Services for Inpatient Facility and Hospital Visits</i>	100% per visit No deductible applies	Not Covered
<i>Administration of Anesthesia</i>	100% No deductible applies.	Not Covered
<i>Allergy Testing and Treatment</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<i>Allergy Injections</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<i>Immunizations when not part of the physical exam</i>	\$10 copay per visit after then the plan pays 100% No deductible applies.	Not Covered
<i>Prenatal Visits</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Emergency Medical Services</i>		
<i>Hospital Emergency Facility</i>	\$50 copay per visit then the plan pays 100% No deductible applies	Not Covered
<i>Non-Emergency Care in a Hospital Emergency Room</i>	Not Covered	Not Covered

Important Notice:

A separate **hospital** emergency room **copay** or **deductible** applies for each visit to an emergency room for emergency care. If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your **copay** or **deductible** is waived.

Covered expenses that are applied to the emergency room **copay** or **deductible** cannot be applied to any other **copay** or **deductible** under your plan. Likewise, covered expenses that are applied to any of your plan's other **copays** or **deductibles** cannot be applied to the emergency room **copay** or **deductible**.

Urgent Care Services

Urgent Medical Care <i>(at a non-hospital free standing facility)</i>	\$25 copay per visit then the plan pays 100%	Not Covered
	No deductible applies	

Non-Urgent Use of Urgent Care Provider <i>(at a non-hospital free standing facility)</i>	Not Covered	Not Covered
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Important Notice:

A separate **urgent care copay** or **deductible** applies for each visit to an **urgent care provider** for **urgent care**. If you are admitted to a **hospital** as an inpatient immediately following a visit to an **urgent care provider**, this **copay** or **deductible** is waived.

Covered expenses that are applied to the **urgent care copay** or **deductible** cannot be applied to any other **copay** or **deductible** under your plan. Likewise, covered expenses that are applied to your plan's other **copays** or **deductibles** cannot be applied to the **urgent care copay** or **deductible**.

PLAN FEATURES NETWORK OUT-OF-NETWORK

Outpatient Diagnostic and Preoperative Testing

Diagnostic and Preoperative Testing <i>(except complex imaging services)</i>	100% per procedure	Not Covered
	No deductible applies.	

Complex Imaging Services

Complex Imaging	100% per test	Not Covered
	No deductible applies.	

Diagnostic Laboratory Testing

Performed at a Hospital Outpatient Facility	100% after \$ 10 PCP copay	Not Covered
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Diagnostic X-Rays		
Diagnostic X-Rays (except Complex Imaging Services)	100% after \$ 10 PCP copay	Not Covered
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery		
Outpatient Surgery	100% per visit/surgical procedure	Not Covered
	No deductible applies.	
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses		
Birth Center	100% per admission	Not Covered
	No deductible applies.	
Hospital Facility Expenses	100% per admission	Not Covered
Room and Board (including maternity)	No deductible applies.	
Other than Room and Board	100% per admission	Not Covered
	No deductible applies.	
Skilled Nursing Inpatient Facility	100% per admission	Not Covered
	No deductible applies.	
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits		
Home Health Care(Outpatient)	100% per visit	Not Covered
	No deductible applies.	
Private Duty Nursing (Outpatient)	100% per visit	Not Covered
	No deductible applies.	
Hospice Benefits		
Hospice Care –Facility Expenses (Room & Board)	100% per admission	Not Covered
	No deductible applies.	
Hospice Care – Other Expenses during a stay	100% per admission	Not Covered
	No deductible applies.	

<i>Hospice Outpatient Visits</i>	100% per visit	Not Covered
No deductible applies.		
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Infertility Treatment</i>		
<i>Basic Infertility Expenses</i> Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<i>Comprehensive Infertility Expenses</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Artificial Insemination Maximum Benefit*	6 courses of treatment per lifetime*	Not Covered
Ovulation Induction Maximum Benefit*	6 courses of treatment per lifetime*	Not Covered
*Does not apply toward the plan coinsurance limit.		
<i>Advanced Reproductive Technology (ART) Expenses</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum per lifetime*	\$100,000*	Not Covered
*Does not apply toward the plan coinsurance limit.		

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Obesity Treatment Surgical and Non Surgical		
Outpatient Obesity Treatment (non surgical)	100% per visit No deductible applies.	Not Covered
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)	100% per admission No deductible applies.	Not Covered
Related Outpatient Morbid Obesity Surgery Services	100% per service No deductible applies.	Not Covered

Transplant Services Facility and Non-Facility Expenses

Your coverage will be considered in-network if provided at a participating Institutes of Excellence facility only. Your coverage will be considered out-of-network if it is not provided at an Institutes of Excellence facility.

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
Facility Expenses	100% per admission. No deductible applies.	Not Covered	Not Covered
Physician (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Other Covered Health Expenses		
Acupuncture (Please refer to pg. 23 in the Booklet for coverage details)	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Ground, Air or Water Ambulance	100% No deductible applies.	Not Covered
Diabetic Equipment, Supplies and Education	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

<i>Durable Medical and Surgical Equipment</i>	100% per item No deductible applies.	Not Covered
<i>Jaw Joint Disorder Treatment</i>	100% per visit No deductible applies.	Not Covered
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<i>Prosthetic Devices</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Outpatient Therapies</i>		
<i>Chemotherapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<i>Infusion Therapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<i>Radiation Therapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Short Term Outpatient Rehabilitation Therapies</i>		
<i>Outpatient Physical, Occupational, and Speech Therapy combined</i>	\$20 per visit copay then the plan pays 100% No deductible applies.	Not Covered
Combined Physical, Occupational, and Speech Therapy Maximum visits per Calendar Year	60 visits	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Spinal Manipulation		
	\$20 per visit copay then the plan pays 100%	Not Covered
	No deductible applies.	
Spinal Manipulation Maximum visits per Calendar Year	20 visits	20 visits

Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
Preferred Generic Prescription Drugs		
For each 30 day supply	\$10	Not Covered
For more than a 30 day supply but less than a 61 day supply for retail pharmacy	\$20	Not Covered
For more than a 61 day supply but less than a 91 day supply for retail pharmacy	\$30	Not Covered
For more than a 30 day supply but less than a 91 day supply for mail order pharmacy	\$10	Not Covered
Preferred Brand-Name Prescription Drugs		
For each 30 day supply	\$20	Not Covered
For more than a 30 day supply but less than a 61 day supply for retail pharmacy	\$40	Not Covered
For more than a 61 day supply but less than a 91 day supply for retail pharmacy	\$60	Not Covered
For more than a 30 day supply but less than a 91 day supply for mail order pharmacy	\$20	Not Covered

Non-Preferred Generic Prescription Drugs

For each 30 day supply	\$10	Not Covered
For more than a 30 day supply but less than a 61 day supply for retail pharmacy	\$20	Not Covered
For more than a 61 day supply but less than a 91 day supply for retail pharmacy	\$30	Not Covered
For more than a 30 day supply but less than a 91 day supply for mail order pharmacy	\$10	Not Covered

Non-Preferred Brand-Name Prescription Drugs

For each 30 day supply	\$35	Not Covered
For more than a 30 day supply but less than a 61 day supply for retail pharmacy	\$70	Not Covered
For more than a 61 day supply but less than a 91 day supply for retail pharmacy	\$105	Not Covered
For more than a 30 day supply but less than a 91 day supply for mail order pharmacy	\$35	Not Covered

Coinsurance

	NETWORK	OUT-OF-NETWORK
Prescription Drug Plan Coinsurance	100% of the negotiated charge	Not Covered

The **prescription drug plan coinsurance** is the percentage of **prescription drug covered expenses** that the plan pays after any applicable **deductibles** and **copays** have been met.

Expense Provisions

The following provisions apply to your health expense plan.

This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Copayments Provisions

Copayment, Copay

This is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

Payment Provisions

Payment Percentage

This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the “Plan Payment Percentage”. Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

Maximum Benefit Provisions

Calendar Year Maximum Benefit

The most the plan will pay for covered expenses incurred by any one covered person in a Calendar Year is called the Calendar Year maximum benefit.

The Calendar Year maximum benefit will not deny benefits for certain covered expenses in any one Calendar Year.

General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.